



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

SENTRIX PHARMACY & DISCOUNT LLC

**MFDR Tracking Number**

M4-17-1822-01

**MFDR Date Received**

February 14, 2017

**Respondent Name**

SERVICE LLOYDS INSURANCE COMPANY

**Carrier's Austin Representative**

Box Number 01

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "At this time Sentrix Pharmacy and Discount, LLC respectfully requests for the Texas Department of Insurance to issue an order awarding the requestor with the full reimbursement amount for the services involved in this dispute..." "

**Amount in Dispute:** \$14,173.70

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "CorVel will maintain the requestor, Sentrix Pharmacy & Discount LLC is entitled to \$0.00 reimbursement for pharmaceutical charges incurred on 02/17/16 based on dispute of extent of injury. Carrier accepted as compensable a [compensable injuries]. Based on medical records dated 10/26/15 received from the prescribing doctor... the patient presented for left knee pain... On 07/13/16, CCH Officer, Gerri Thomas, rendered a decision indicating the compensable injury of [date of injury] does not extend to or include loosening of the total knee replacement hardware of the left knee..."

**Response Submitted by:** CorVel

### SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
February 17, 2016	Transdermal wound cream	\$14,173.70	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.305 sets out the procedure for dispute resolution.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 219 — Based on extent of injury
  - W3 — Appeal/reconsideration
  - 242 — Services not provided by network/primary care prov

**Issues**

- Have the relevant compensability issues been resolved?

2. Is the requestor entitled to reimbursement?

### **Findings**

1. The requestor seeks reimbursement for a prescribed transdermal wound cream (compound medication), rendered on February 17, 2016. The insurance carrier denied/reduced the disputed charges with denial reason code "219-Based on extent of injury."

28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

The services in dispute were denied, in part, due to unresolved extent of injury issues. The issues raised and relevant to the services in this medical fee dispute involved whether the compensable injury extended to the left knee. A contested case hearing was held and a decision was issued on July 13, 2016. In its decision, the division concluded that the compensable injury **did not extend** to or include loosening of the total knee replacement hardware of the left knee..." The division finds that the relevant issues were resolved.

2. Review of the submitted prescription for the transdermal wound cream, indicates that compound cream was prescribed for the left knee pain. The division concludes that the services in dispute were rendered by the requestor to treat an injury found to be non-compensable according to the Contested Case Hearing decision discussed above. For that reason, no reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
March 10, 2017

\_\_\_\_\_  
Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

***Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.***